EMPLOYEE SICK LEAVE ACT (ESLA) COMPLAINT FORM

Illinois Department of Labor
160 North LaSalle Street, Suite #C-1300
Chicago, Illinois 60601
(312) 793-6797

PLEASE PRINT OR TYPE ALL INFORMATION
Use additional sheets if necessary. Attach copies of all supporting documentation and other evidence. A copy of this sheet will be sent to the employer.

FOR OFFICE USE ONLY: Claim Number _____   Received _____

I. EMPLOYER INFORMATION:

Employer Name

Address

City   State   Zip Code

Corporation Name, if any

Employer Contact Name   (   ) Contact Phone #

Number of Employees

Is this a Government Agency?   Yes   No

Is this employer still in business?   Yes   No

II. EMPLOYEE INFORMATION:

Last Name   First Name

Address

City   State   Zip Code

(   ) Employee Phone #

Email

Name of Second Contact   (   ) Second Contact Phone #

Email

III. COMPLAINT DETAILS:

1. Did you request leave to care for a relative? (i.e.: child, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent?)   Yes   No

2. Was this leave in order to assist your relative with his or her personal illness, injury, or medical appointment?   Yes   No

3. Name of Relative: _____

4. Relationship to Complainant: (i.e.: I requested time off to assist my child, spouse, parent, etc.)

5. Dates for which you requested ESLA leave:

6. Was leave granted on the same terms that would apply for your own personal illness, injury, or medical appointment?

Yes   No

7. Were you retaliated against for requesting leave or for filing a complaint against your employer for a violation of ESLA?

Yes   No

8. Please give any other details regarding the failure to give leave under the ESLA or retaliation:

IV. CERTIFICATION & SIGNATURE:

Please sign, date, and return this form with two (2) copies of any attachments to the Illinois Department of Labor at the address listed at the top of this form.

I HEREBY CERTIFY that the statements herein, including attachments, are true and accurate to the best of my knowledge and belief. I understand that acceptance of this complaint by the Illinois Department of Labor does not guarantee any specific result. I authorize the Illinois Department of Labor to receive any monies paid and to mail such monies to me at my own risk.

Date: _____   Employee's Signature _____

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